FloridaCoast
Pain and Spine Center

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PERSONAL HEALTH INFORMATION

Instructions: Please complete, initial where appropriate and sign this form, blanks or items not checked are assumed to be non-applicable or specifically not authorized for release. By signing this form, you are authorizing the release of medical records and personal healthcare information from/to another facility.

**I HEREBY AUTHORIZE RELEASE FROM: [ ] FLORIDA COAST PAIN AND SPINE CENTER OR:**

[X] _____

(NAME OF OTHER RELEASING FACILITY and PHONE NUMBER)

**TO DISCLOSE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORD OF:**

NAME (Last): _____ (First): _____ (MI) ____

DOB: _____ Social Security # XXX-XX-_____ Phone: _____

**THIS INFORMATION IS TO BE DISCLOSED TO: (Include Address)**

[X] **FLORIDA COAST PAIN AND SPINE CENTER**

*Intracoastal Office:* 4796 Hodges Blvd., Suite 101 Jacksonville, FL 32224 Main: (904)-449-PAIN(7246) Fax number: (904)-719-7571

*Northside Office:* 2386 Dunn Avenue, Suite 111 Jacksonville, FL 32218 Main: (904)-449-PAIN(7246) Fax number: (904)-719-7571

[ ] (Insert address of additional locations)

**FOR THE PURPOSE OF:** [X] Continued Treatment [ ] Billing [ ] Personal [ ] Other: _____

**THE FOLLOWING INFORMATION IS TO BE DISCLOSED:**

| | | |
|---|---|---|
| [ ] Entire Medical Record | [ ] Rehabilitation Documentation | [ ] Operative report |
| [ ] Emergency Report | [ ] History & Physical | [ ] X-ray (Imaging) Reports |
| [ ] Laboratory Reports | [ ] Billing Records | [ ] Consultation Reports |
| [ ] Discharge Summary | [ ] Radiology Reports | [ ] Other: |

✓ ____ (Initial) I UNDERSTAND THAT THIS MAY INCLUDE information relating to HIV/AIDS, mental health, treatment and screening for alcohol or drug abuse, and/or sexually transmitted diseases.

**POSSIBILITY OF REDISCLOSURE:** I understand that any information released may be subjected to re-disclosure and no longer protected by state and federal regulation.

**EXPIRATION AND REVOCATION:** I understand that this authorization is valid for 6 months from the date I sign it, or the duration of ✓_____ (event). I have the right to revoke this authorization in writing at any time. The revocation will take place on the day it is received, except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

**CONDITION OF TREATMENT:** I understand *FLORIDA COAST PAIN AND SPINE CENTER* or agency cannot condition treatment upon signing this authorization.

✓_____ ✓_____

Signature of Patient/Guardian/Legal Representative ✓Date Signed

_____ _____

Relationship to Patient Witness/Date